Medication Assistance Training Roster

Wyoming Department of Health
Behavioral Health Division

Complete ALL information on this form and it must be legible in order for your certification to be valid.

DATE: _____ CITY: _____

TRAINER: _____ ☐ **Student Training** ☐ **Trainer Training** (for DD Section use only)

Office use only Record Number	First Name	Last Name	Home Street Address City, State, Zip	Personal Phone Number Personal Email Address	Name of Organization	Test Score

Trainer mail this Roster, Surveys, and Final Exams to: DD Section, Attn: Jessica Fancher, 6101 Yellowstone Rd, Suite 220, Cheyenne, WY 82002